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Health Insurance Status in New Jersey After Implementation of the Affordable Care Act

Joel C. Cantor, Sc.D.
Dorothy Gaboda, M.S.W., Ph.D.
Jose Nova, M.S.
Kristen Lloyd, M.P.H.

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The authors are solely responsible for all information, analyses, and conclusions presented in this report.

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Executive Summary

This report is intended to assist state policymakers, health plans, health care providers and others in New Jersey to prepare for the implementation of coverage provisions of the Patient Protection and Affordable Care Act (ACA) in 2014. We have drawn on available data sources and relevant publications to estimate the likely numbers and demographic and health characteristics of non-elderly persons (under 65) in New Jersey who will be eligible for and enroll in Medicaid/NJ FamilyCare, subsidized private coverage through a health insurance exchange, unsubsidized private coverage, employer-sponsored coverage, and the residual uninsured. We applied information about current eligibility to develop estimates of those covered by various sources as well as those eligible for coverage but uninsured in 2009. We then apply the 2014 ACA rules to these data to estimate enrollment and eligibility changes had those rules been in place in 2009. This procedure generates the following estimates of changes in coverage that can be expected with implementation of the ACA:

- The number of uninsured in New Jersey will decline from 14.5% of the non-elderly population to 8.6%, increasing the number of covered persons by about 444,000.
- The non-group health insurance market will gain the most covered lives, increasing from 2.8% of the non-elderly to 7.6%, an increase of about 362,000 persons. Of those enrolled in non-group coverage after reform, more than half would be eligible for federal tax credit subsidies.
- Medicaid/NJ FamilyCare will also expand substantially under reform, increasing from covering 13.6% to 16.7% of the non-elderly in the state, an expansion of about 234,000 individuals. More than half of this projected increase will be non-parent adults (132,000), although we project that the number of enrolled children will also increase.
- The percentage of persons with employer-sponsored coverage will decline slightly.

We estimate large increases in non-group coverage at all income levels, with the greatest increases among those below 400% of the federal poverty level (FPL). Added Medicaid

coverage is concentrated below the 138% FPL threshold, but we also project a modest increase above that level among children eligible for NJ FamilyCare.

The health status of populations eligible for coverage under the ACA will differ somewhat from currently enrolled populations:

- The average health of the population eligible for Medicaid/NJ FamilyCare under the ACA will be roughly the same or better than the currently enrolled population. If Medicaid take up is high after reform, enrollees will mirror this health status profile, but more adverse risk selection is probable if take up is low.
- The population eligible to purchase non-group coverage after reform will be somewhat sicker on average than their peers with current non-group coverage, which includes standard individual market plans, the Basic and Essential Plan and student health plans. This difference is reflected mainly in lower health status of adults ages 35 to 64 who will be eligible to enroll in non-group coverage under ACA rules. Like Medicaid, low take up of non-group coverage would increase the risk of adverse selection into this market. The risk profile of adults eligible for subsidies through health insurance exchanges is somewhat worse than those not eligible for subsidies.

The average cost of enrolled populations under the ACA will depend on the extent of compliance with the coverage enrollment mandate, thus outreach and other measures to assure high compliance will be important as the ACA is implemented. Differences in health status of populations eligible for subsidies and those that are not underscore the need to establish a health insurance regulatory structure that does not encourage higher risk persons to purchase coverage in the new health insurance exchange. The estimates in this report are subject to sampling variance and other possible sources of error. However, these estimates are consistent with other published state-level projections and we believe they provide a reasonable starting point for planning New Jersey's response to the ACA.

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Introduction

The 2010 Patient Protection and Affordable Care Act (ACA) seeks to increase the number of persons with health insurance coverage by expanding eligibility for Medicaid to most persons under 138% of the federal poverty level (FPL) and making federal tax credits and cost sharing subsidies available to individuals above that income level up to 400% FPL. These coverage expansions become effective January 1, 2014 along with the requirement that most people obtain health coverage or face a financial penalty. This report provides estimates of the number and characteristics of New Jersey residents who will be eligible for coverage expansions under the ACA and the number likely to enroll in various types of coverage including Medicaid/NJ FamilyCare, subsidized and non-subsidized non-group private coverage, and employer-sponsored coverage, as well as those who will remain uninsured after reform.

The impact of coverage provisions of the ACA on changes in the percentage of persons uninsured is likely to vary widely across the states, depending on states' uninsured rates prior to reform, income disruptions, and the size and characteristics of immigrant populations. Buettgens, Holahan, and Carroll (2011) estimate individual state post-ACA uninsurance rates ranging from 2.9% for Massachusetts to 13.5% for Arizona. Several reports have generated state-level estimates of the impact of reform on coverage, but these estimates vary based upon the data source used and modeling techniques, such as adjustments to Medicaid enrollment estimates, assumptions about participation rates, or inclusion of economic factors. Some state estimates are the product of sophisticated microsimulation models that make detailed assumptions about enrollment behavior and other factors, but by necessity, models that produce estimates for all states cannot take some important circumstances of individual states into account. These models also often lack details needed by individual states' policymakers to support key decisions about how best to respond to the requirements of the ACA.

This report builds on the most current available data and a rigorous body of published literature on health insurance enrollment behavior to generate best estimates of important parameters to support health policy decisions in New Jersey. The most current available data on coverage, the 2009 American Community Survey, provides the basis for these estimates.

We also draw extensively on the 2009 New Jersey Family Health Survey (NJFHS) for health status and other information. The NJFHS was designed and conducted by the Rutgers Center for State Health Policy to serve a broad range of policy analysis needs for New Jersey. Other information, including data from state administrative systems and parameters drawn from published studies, are applied to the study datasets to provide estimates of enrollment in various sources of coverage and the number of uninsured persons. Eligibility and enrollment estimates are arrayed by age group, family income (by percentage of the FPL), and type of coverage. Distribution of health status by age group and type of coverage are also provided. Baseline estimates (without reform) reflect distributions in 2009 and "post-implementation" estimates reflect 2009 coverage distributions if the 2014 ACA rules had been in effect in 2009. In the Discussion section below, we comment on the possible impacts of demographic changes between 2009 and 2014 on coverage distributions.

Data and Methods

Several data sources were used to develop the estimates contained in this report. We used the 2009 American Community Survey (ACS) as the basis for our estimates of current health coverage and eligibility for public coverage among those not insured before health reform, downloaded from the Integrated Public Use Microdata Series at the Minnesota Population Center (Ruggles et al., 2010). We excluded individuals living in institutions or group quarters and those aged 65 and over. The ACS provides coverage estimates which are generally consistent with those from the Current Population Survey (CPS) and the National Health Interview Survey, with the exception of direct purchase coverage (Turner, Boudreaux and Lynch, 2009). The ACS was selected as the basis for estimates in this report because it provides a large representative sample of state residents and its estimates of enrollment in public and private coverage are more recent and more closely match state administrative records than do merged years (required for sufficient samples) of the CPS, the other federal data source commonly used for state-level analyses of coverage (A table comparing estimates across data sources is provided in Appendix A).

We made several adjustments to reported insurance coverage, based on previous studies. In addition to the commonly-noted problem of underreporting of public coverage in surveys, the ACS does not use state-specific names for Medicaid and CHIP programs (e.g., NJ FamilyCare). In New Jersey, as is the case nationally, administrative records count a larger number of individuals enrolled in Medicaid/CHIP than are captured in survey data. Based on a previous study demonstrating misreporting of Medicaid/CHIP coverage as privately purchased coverage (Cantor et al., 2007), we reclassified individuals reporting non-group coverage who had family incomes which made them eligible for Medicaid/NJ FamilyCare to that coverage, provided that the adults had been in the US for at least five years. While we were not able to

adjust reported household income to fit the definition of eligible income for a health insurance eligibility unit, we used 138% of FPL (the new income-based Medicaid eligibility threshold of 133% FPL plus the 5% income disregard) as the eligibility cutoff for NJ FamilyCare parents pre-ACA as well as post-ACA to better simulate eligible income. As a result of these adjustments, the number of individuals enrolled in Medicaid/NJ FamilyCare was increased from 17.4% to 5.7% below administrative counts as of July 2009.

We also reclassified a small number of individuals reporting non-group coverage but also reporting that they were self-employed and incorporated to employer-sponsored coverage (ESI). Even though the ACS measures insurance coverage at the point in time of the survey, many individuals reported more than one type of insurance coverage, including Medicaid plus other insurance. Therefore, we developed a summary insurance coverage variable for these tables, using a hierarchy giving first preference to reports of Medicaid/NJ FamilyCare coverage, then ESI, then private/non-group insurance, then other public programs including Medicare (other than "dual eligibles" also enrolled in Medicaid), military (TRICARE) and Veterans Health Administration programs, with the residual reporting no form of coverage coded as uninsured.

The 2009 New Jersey Family Health Survey (NJFHS), conducted and analyzed by the Rutgers Center for State Health Policy, was used for estimating percentages of those having ESI in firms under 51, 51-100, and over 100 employees and those who had an offer of ESI but had not taken up coverage. The NJFHS was also used for estimating health status. Three sets of health measures are presented for New Jersey residents by age group and type of coverage to illustrate changes in average health status with implementation of the ACA, by comparing the health status of those currently enrolled with all those who would be eligible under the ACA. NJFHS measures of the percentage of individuals reported in fair or poor health (versus good, very good, or excellent) and the percentage reported with asthma, diabetes or any other serious or long-lasting health condition are shown for both children and non-elderly adults. In addition, measures of acute symptoms reported within three months of the interview are shown for adults. Detailed information about NJFHS methods is available on the CSHP website (http://www.cshp.rutgers.edu/Downloads/8610.pdf).

We used the most relevant and well-conducted recent studies to develop key assumptions to generate our estimates. Many of these produced state-specific estimates, while others made separate estimates by region of the U.S. Estimates of take up by children eligible for NJ FamilyCare post-ACA were based on Kenney et al. (2010). We used the high end of the Kenney et al. confidence interval (82.2%), since New Jersey is already employing the majority of practices recommended to increase enrollment, and enrollment efforts are likely to benefit from the additional activities associated with health reform. Estimates of take up by adults newly eligible for Medicaid post-ACA used an expected rate of 73%, based on Buettgens, Holahan and Carroll (2011) and Holahan and Headen (2010). We developed estimates of non-group coverage post-ACA using assumptions from Buettgens, Holahan and Carroll (2011) and

Buettgens, Garrett and Holahan (2010). Specifically, we draw assumptions from these sources regarding proportions of individuals who could be expected to switch from ESI and those uninsured who would likely enroll in non-group coverage. Appendix B provides additional details of modeling assumptions.

We adjusted our estimates of those enrolled in coverage before and after the ACA using New Jersey Medicaid administrative records and income distributions for post-ACA non-group and uninsured populations using Buettgens, Garrett and Holahan (2010), which were based on microsimulation results.

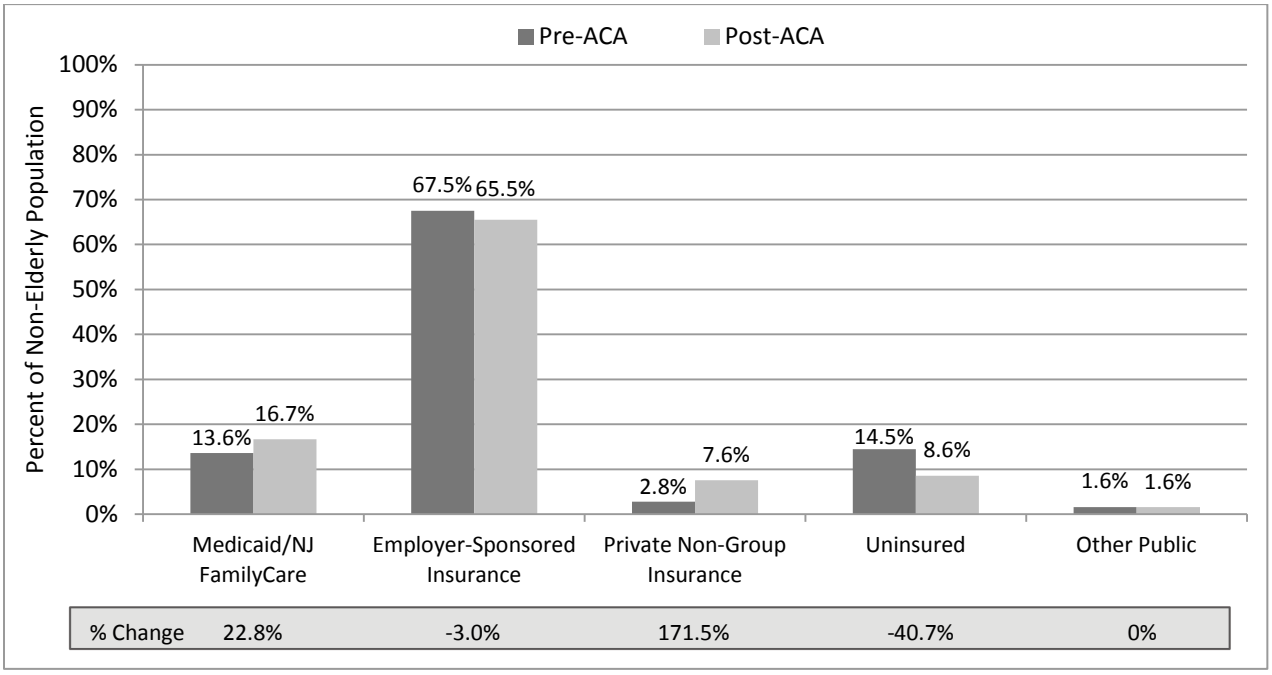
Although undocumented immigrants are likely to be undercounted in surveys, some are likely to be included. While the ACS has no direct measure of documentation status for non-citizen immigrants, we have adjusted all estimates in Tables 1 and 2 below to account for undocumented immigrants, using information from published research (Passell and Cohn, 2011).

Results

Eligibility and Enrollment Post-ACA

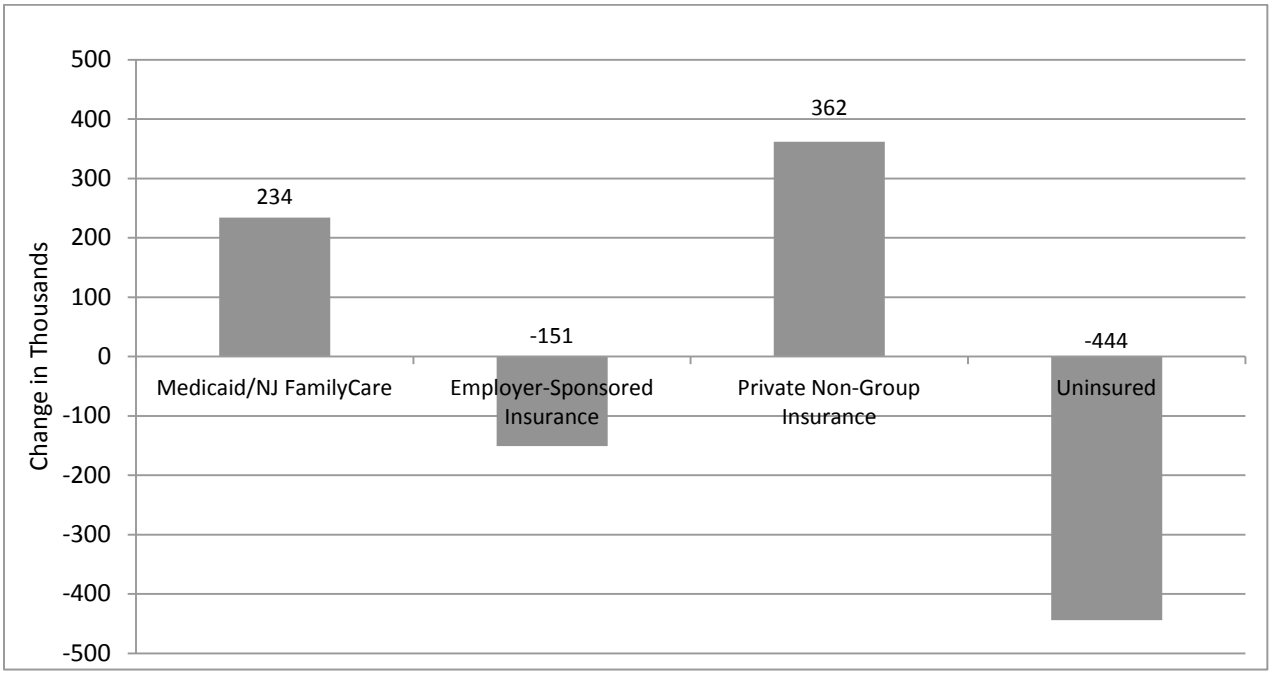
Overall, our estimates indicate that the composition of health coverage for the non-elderly in New Jersey will change substantially after implementation of the ACA for those covered by Medicaid/NJ FamilyCare, those covered by non-group insurance, and those who are uninsured (Figures 1 and 2). The number of uninsured will decrease by 40.7%, from 14.5% to 8.6% of the non-elderly population, a post-reform uninsured rate that is likely to be similar to the national average. The Congressional Budget Office (2010) estimates that the uninsured rate in the U.S. after health reform will be 8% and Buettgens, Holahan and Carroll (2011) project a national rate of 8.7%. The share of those under 65 covered by Medicaid/NJ FamilyCare will increase by 22.8% from 13.6% to 16.7%, and the share covered under private non-group insurance will increase by 171.5% from 2.8% to 7.6%. The number covered by ESI is expected to decrease only slightly.

Figure 1: Composition of Insurance Coverage for New Jersey Non-Elderly Population, Before and After Implementation of the ACA



Source: Estimates by Rutgers Center for State Health Policy, See Text

Figure 2: Change in Coverage by Type of Insurance, Before and After Implementation of the ACA



Source: Estimates by Rutgers Center for State Health Policy, See Text

Table 1 shows detailed estimates of those eligible, enrolled, and eligible-but-not-enrolled for each type of coverage before and after implementation of the ACA. We estimate that the number of children eligible for Medicaid or NJ FamilyCare will not increase after the ACA, but eligibility will change for adults, with parents over 138% FPL moving to the non-group exchanges for their coverage, and many new childless adults becoming eligible. We project that enrollment of children will increase by 17%, while enrollment of non-elderly childless adults will increase by 64%. Most of these would be previously uninsured.

We were not able to directly estimate possible changes in decisions of employers to offer coverage to their employees, so we do not project changes in eligibility for ESI. However, we use the results of microsimulation studies which did model switching from ESI to exchange-based coverage (Buettgens, Holahan and Carroll, 2011; Buettgens, Garrett and Holahan, 2010) to project that some individuals with small or medium size group ESI will change to Medicaid and others will be eligible for subsidies and move to non-group coverage. Nevertheless, ESI will continue to provide coverage to nearly two-thirds of the non-elderly population in New Jersey even after ACA implementation. Based on employment information from the ACS and NJFHS, we estimate that:

- About 60% of those under 65 covered by ESI will be workers, 37% will be dependents, and only about 3% will be early retirees. It is possible that we have underestimated the percentage of retirees, due to the difficulty of identifying individuals who have coverage from a job from which they retired early but are working at another position.
- Approximately 23% of those reporting ESI coverage are covered by federal, state, or local government employers.

Private non-group insurance is expected to increase very substantially under reform, with two-thirds of new enrollees coming from among currently uninsured individuals who will be eligible for subsidies. The remaining new enrollees are projected to move from ESI because of affordability exemptions. Currently, sole proprietors (self-employed with no employees) are not eligible to purchase coverage in the small-group market in New Jersey, while other states permit such "groups of one" to purchase as a small employer.

- Of the expected enrollees in non-group coverage after the ACA, we expect between 29,000 and 45,000 (5.1% to 7.9%) to be sole proprietors.

We estimate that nearly three-fifths (59.6%) of persons eligible for non-group coverage after reform will also be eligible for federal premium tax credits, and that almost as many (55.8%) of those enrolled in post-reform non-group coverage will receive these subsidies.

We estimate that the uninsured rate will decrease more for children (46.0%) than for non-elderly adults (39.9%) in New Jersey following implementation of reform.

- Of the 648,000 adults estimated to remain uninsured after ACA implementation, nearly 40% (263,000) may be undocumented immigrants.

Table 1: New Jersey Non-Elderly (<65) Population (in thousands) (2009) by Type of Coverage, With and Without the ACA

	Pre-ACA			Post-ACA[b]			
Coverage	Eligible	Enrolled	Unenrolled Eligible	Eligible	Enrolled	Unenrolled Eligible	% Change
Medicaid/NJ FamilyCare Total[a]	1,264	1,026	237	1,342	1,260	82	22.8
Children (<19)	719	596	123	719	698	21	17.1
Parents	296	224	72	236	223	12	-0.3
Other non-elderly adults	249	207	42	388	339	49	64.0
Employer-Sponsored Insurance (ESI) Total	5,266	5,089	177	5,266	4,938	328	-3.0
Small group (<50)	908	881	27	908	791	117	-10.2
Medium group (51-100)	193	188	5	193	140	53	-25.5
Large group	4166	4,020	145	4,166	4,007	158	-0.3
Private Non-Group Insurance [c]	--	211	--	681	573	107	171.5
Subsidy eligible[d]	--	--	--	406	320	86	
Not subsidy eligible	--	--	--	274	253	21	
Other Public[e]	--	122	--	--	122	--	0.0
Uninsured	--	1,092	--	--	648	--	-40.7
Children	--	142	--	--	77	--	-46.0
Non-elderly adults	--	951	--	--	571	--	-39.9

Source: Rutgers Center for State Health Policy (see text for data sources)

a. Includes Medicare/Medicaid dual eligible; adult eligiblity adjusted for 5-year waiting period; excludes those in institutions and group quarters and NJ FamilyCare Advantage

b. Applies 2014 ACA rules to 2009 estimates

c. Includes non-group market and student plans

d. Includes persons between 139-400% FPL, legally resident, and not exempt from or non-compliant with federal coverage mandate

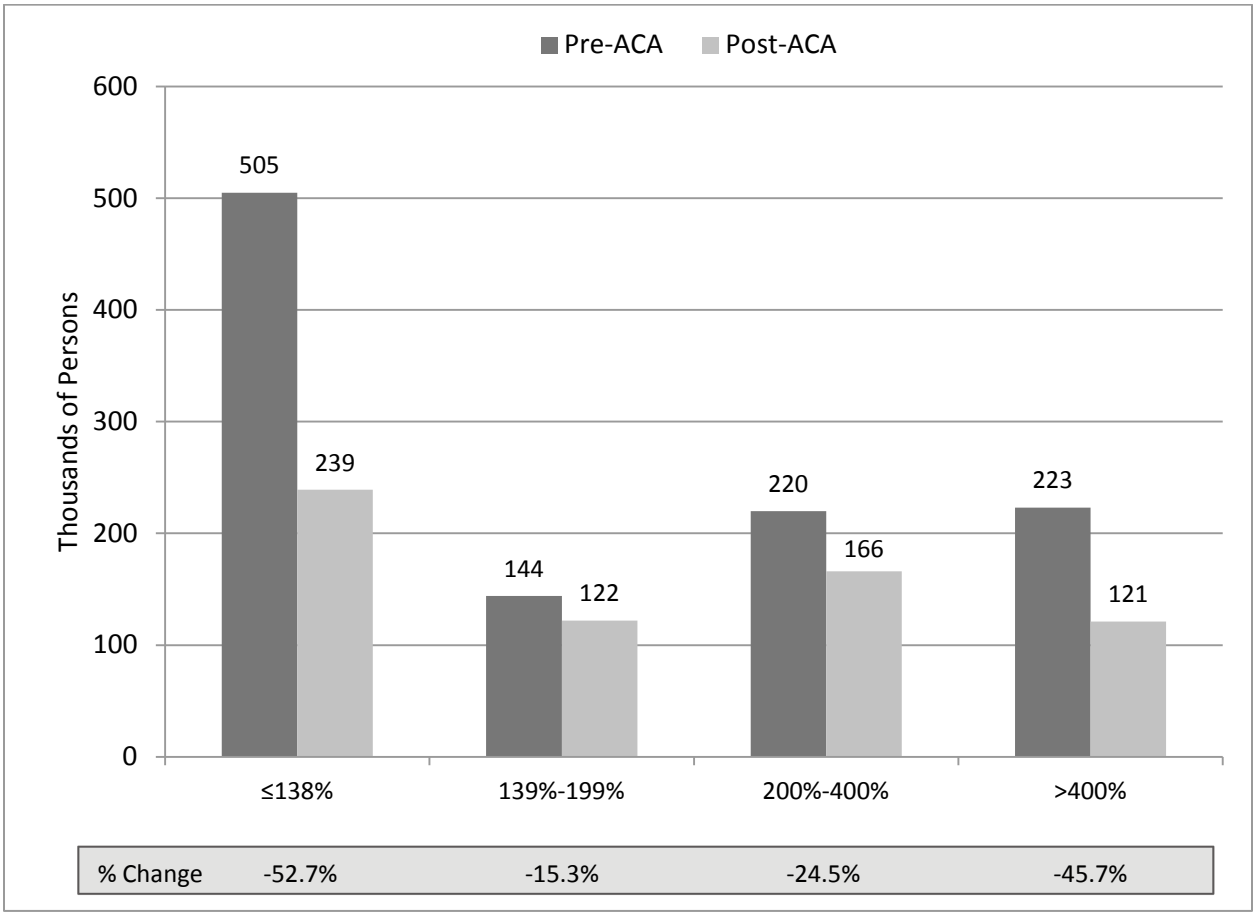
e. Includes Medicare except persons also enrolled in Medicaid (i.e., dual eligibles), TRICARE and Veterans Health Administration programs

-- indicates not applicable

Enrollment by Income Level

Figure 3 and Table 2 present estimates of coverage by income level before and after implementation of the ACA. For those at the lowest income levels, enrollment in Medicaid/NJ FamilyCare increases substantially. We estimate that non-group coverage will increase by 93,000 people for the lowest income group, with the increase coming mainly from those who do not have access to affordable ESI. Many of these are foreign-born adults not eligible for Medicaid because they have been legal residents of the U.S. for less than five years. The number of uninsured also decreases for all other income levels, from a 15.3% decrease for those from 139% to 199% FPL to a 45.7% decrease for those over 400% FPL.

Figure 3: Number of Non-Elderly Uninsured (in thousands) by Federal Poverty Level (FPL) Before and After Implementation of the ACA



Source: Estimates by Rutgers Center for State Health Policy, See Text

Table 2: New Jersey Non-Elderly (<65) Population (in thousands) (2009) by Family Income & Type of Coverage, With and Without the ACA

Excludes Persons Enrolled in Medicare but not Medicaid (i.e., not dual-eligible), TRICARE, and Veterans Health Administration Programs

Ratio to Federal Poverty Level (FPL) and Coverage	Pre-ACA Enrolled	Post-ACA Enrolled[b]	% Change
Up to 138% FPL			
Medicaid/NJ FamilyCare[a]	891	1,136	27.5
Employer-sponsored insurance	145	73	-49.7
Non-group insurance[c]	8	101	1162.5
Uninsured	505	239	-52.7
139% to 199% FPL			
Medicaid/NJ FamilyCare[a]	104	76	-26.9
Employer-sponsored insurance	222	211	-5.0
Non-group insurance[c]	11	72	554.5
Uninsured	144	122	-15.3
200% to 400% FPL			
Medicaid/NJ FamilyCare[a]	31	48	54.8
Employer-sponsored insurance	1,316	1,254	-4.7
Non-group insurance[c]	52	152	192.3
Uninsured	220	166	-24.5
Over 400% FPL			
Employer-sponsored insurance	3,406	3,400	-0.2
Non-group insurance[c]	140	248	77.1
Uninsured	223	121	-45.7

Source: Rutgers Center for State Health Policy (see text for data sources)

a. Includes Medicare/Medicaid dual eligible; adult eligiblity adjusted for 5-year waiting period; excludes those in institutions and group quarters and NJ FamilyCare Advantage

b. Applies 2014 ACA rules to 2009 estimates

c. Includes non-group market and student plans

Eligibility for the Basic Health Program

The ACA offers states the option to implement a Basic Health Program (BHP) for low-income residents who are ineligible for Medicaid. Under this option, the federal government would provide support to states to cover eligible individuals directly, rather than through a health insurance exchange. Two groups can qualify for the BHP (Dorn, 2011):

- Adults who are citizens or lawfully present immigrants under age 65 with incomes between 138% and 200% FPL who do not have an affordable and comprehensive offer of ESI.
- Legally present persons with incomes below 138% FPL who are ineligible for Medicaid because they have not been lawful residents for five years.

We estimate that at a point in time 65,000-75,000 adults may be eligible for the BHP. Using ACS data, we calculated that about 25,000 legal immigrant adults below 138% FPL are not eligible for Medicaid because of the length of their residency in the U.S. In addition, based on estimated percentages from Buettgens and Hall (2011), we project that between 42,000 and 50,000 additional adults in this income range will not have an affordable ESI option. Over time, the number of individuals eligible for a BHP would be greater as incomes fluctuate (Sommers and Rosenbaum, 2011). The BHP would, in concept, improve rates of enrollment and retention of individuals whose incomes change over time by reducing the need for enrollment transitions between Medicaid and Exchange plans.

Health Status of Eligible Populations

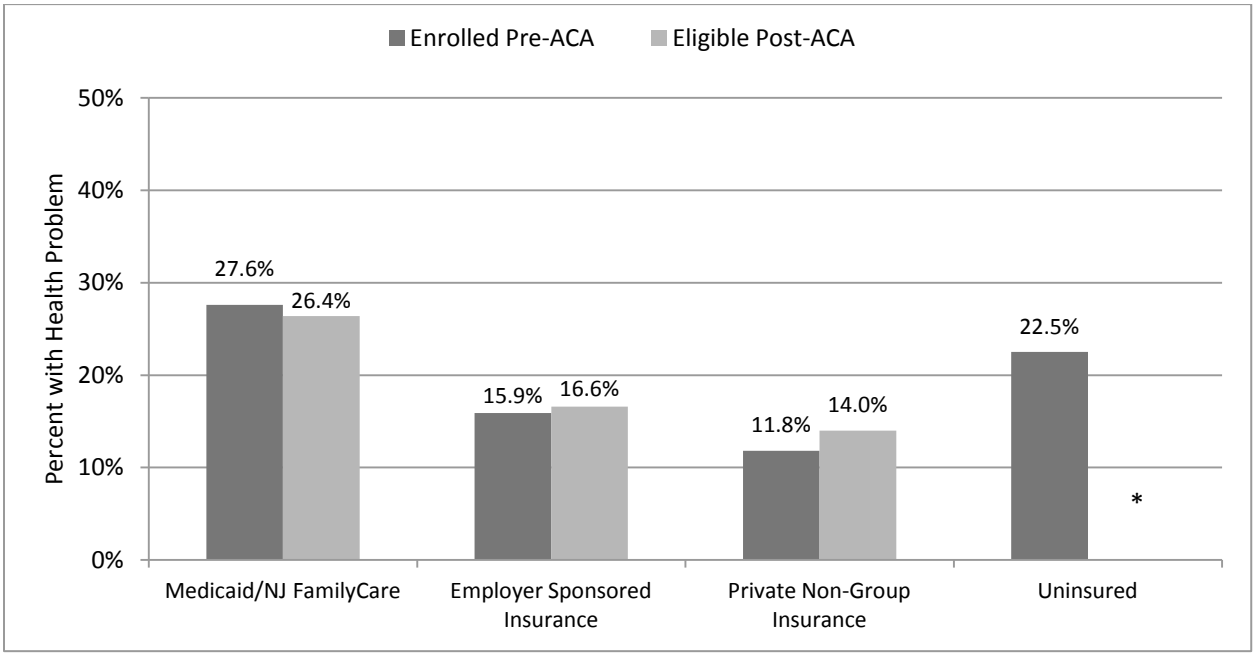
Measures of health status of the New Jersey population are shown in Figures 4 and 5 and Table 3. Data are arrayed by age group and coverage status for the current (2009) population and the population that would be eligible for coverage under the ACA once fully implemented based on estimates from the New Jersey Family Health Survey. Table 4 demonstrates the close association between each of the health measures and reported health services utilization in the New Jersey non-elderly population. For example, compared to non-elderly adults with no chronic conditions, those reported with one or more conditions (asthma, diabetes, or other long-lasting condition) are over fourfold more likely to have been hospitalized in the prior year and over twice as likely to have visited doctors at least three times in 12 months.

Overall, this analysis projects that the health of those who will be eligible for Medicaid post-ACA will have similar or better health, on average, compared to current enrollees across all of the age groups examined. Health patterns in the non-group market, however, show a greater risk of adverse health selection. While health status indicators for children and young adults (ages 19-34) who will be eligible to enroll in non-group coverage after reform will differ little from those currently enrolled, the pool of older non-elderly adults (ages 35-64) who will be eligible for non-group coverage is sicker than the current non-group market. (Current non-

group market enrollment shown in this report includes persons with student coverage, "Basic and Essential" plans, as well as those with standard plans in the Individual Health Coverage Program.) In addition, those who are eligible for subsidies in a health insurance exchange show the highest proportion of sick individuals.

These data reflect the average health of persons who would qualify for Medicaid or non-group coverage after reform. If take up rates are very high, the health of average enrollees will closely reflect that of the eligible population. However, lower take up rates are likely to be accompanied by adverse risk selection. For example, one national study estimated that 18.4% of *new* Medicaid enrollees under the ACA would be in fair or poor self-assessed health compared to 10.5% of persons who are newly eligible but remain uninsured (Holahan, Kenney and Pelletier, 2010).

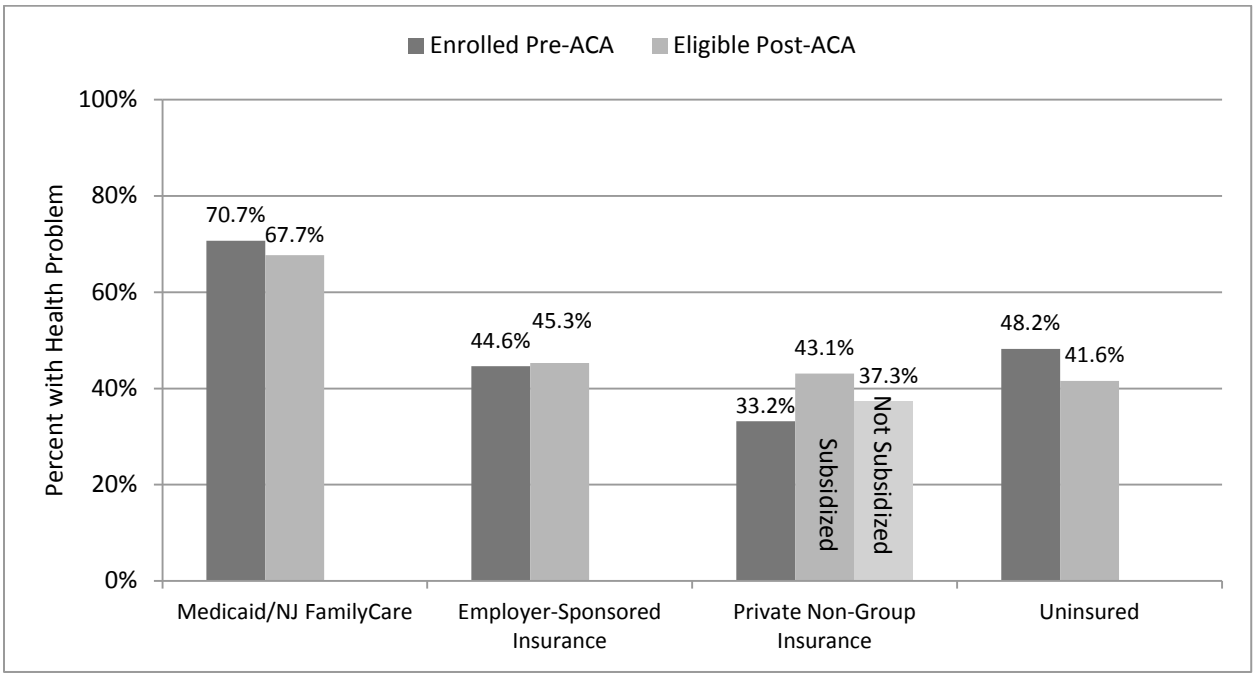
Figure 4: Percentage with Health Problem, Children Under Age 19, Enrolled in 2009 Compared to Eligible under ACA



Source: Estimates by Rutgers Center for State Health Policy, See Text

* Insufficient sample size to support estimates of post-ACA uninsured

Figure 5: Percentage with Health Problem, Adults Age 19-64, Enrolled in 2009 Compared to Eligible under ACA



Source: Estimates by Rutgers Center for State Health Policy, See Text

Table 3: Health Status of New Jersey Non-Elderly (<65) by Age Group & Type of Coverage, With and Without the ACA

Excludes Persons Enrolled in Medicare but not Medicaid (i.e., not dual-eligible), TRICARE, and Veterans Health Administration Programs

	Health Status Measures (% of group)							
	Enrolled Pre-ACA				Eligible Post-ACA			
Age Group and Coverage	Fair/Poor Health	Chronic Condition	Acute Symptom	Any Health Problem	Fair/Poor Health	Chronic Condition	Acute Symptom	Any Health Problem
Children (under 19)	3.2	16.4	--	18.1	3.2	16.4	--	18.1
Medicaid/NJ FamilyCare	9.8	22.5	--	27.6	9.4	20.5	--	26.4
Employer sponsored coverage	1.2	15.7	--	15.9	1.6	16.1	--	16.6
Non-Group	4.7	7.1	--	11.8	1.3	13.3	--	14.0
Uninsured	8.9	13.6	--	22.5	*	*	--	*
Non-Elderly Adults (19-34)	10.5	15.8	25.6	37.1	10.5	15.8	25.6	37.1
Medicaid/NJ FamilyCare	12.2	23.6	34.0	51.5	24.9	15.6	39.5	55.7
Employer sponsored coverage	6.2	19.9	23.2	35.1	7.0	19.8	21.9	33.8
Non-Group	6.6	7.6	28.4	35.1	8.9	11.2	26.4	34.5
Subsidy eligible	--	--	--	--	10.1	8.7	25.9	35.0
Not subsidy eligible	--	--	--	--	7.8	13.6	26.9	34.0
Uninsured	19.5	7.2	27.8	37.3	7.2	6.2	17.7	26.6
Non-Elderly Adults (35-49)	13.7	22.6	32.1	43.8	13.7	22.6	32.1	43.8
Medicaid/NJ FamilyCare	49.1	43.7	69.6	76.0	52.2	35.6	59.2	73.1
Employer sponsored coverage	9.0	22.3	28.5	40.9	8.6	22.5	30.2	42.5
Non-Group	5.5	7.3	10.2	16.5	10.6	18.8	24.2	34.9
Subsidy eligible	--	--	--	--	17.0	23.0	27.7	44.0
Not subsidy eligible	--	--	--	--	6.7	16.2	22.1	29.2
Uninsured	31.8	21.3	46.3	57.0	23.9	18.6	39.4	46.0

continued next page

Table 3: Health Status of New Jersey Non-Elderly (<65) by Age Group & Type of Coverage, With and Without the ACA (continued)

Excludes Persons Enrolled in Medicare but not Medicaid (i.e., not dual-eligible), TRICARE, and Veterans Health Administration Programs

	Health Status Measures (% of group)							
	Enrolled Pre-ACA				Eligible Post-ACA			
Age Group and Coverage	Fair/Poor Health	Chronic Condition	Acute Symptom	Any Health Problem	Fair/Poor Health	Chronic Condition	Acute Symptom	Any Health Problem
Non-Elderly Adults (50-64)	19.0	36.5	37.6	58.8	19.0	36.5	37.6	58.8
Medicaid/NJ FamilyCare	60.3	66.2	77.3	95.2	59.7	56.9	65.8	83.5
Employer sponsored coverage	13.0	36.3	35.3	57.2	13.0	37.5	36.4	58.3
Non-Group	8.3	27.1	19.7	42.8	16.9	27.3	29.4	50.6
Subsidy eligible	--	--	--	--	30.2	28.4	45.5	54.8
Not subsidy eligible	--	--	--	--	10.9	26.8	21.9	48.7
Uninsured	44.1	29.3	43.2	60.3	34.8	30.4	40.4	57.4
All Non-Elderly Adults (19-64)	14.3	24.7	31.8	46.2	14.3	24.7	31.8	46.2
Medicaid/Family Care	36.3	41.3	56.2	70.7	41.2	31.4	51.8	67.7
Employer sponsored coverage	9.6	26.2	29.3	44.6	9.6	26.6	30.0	45.3
Non-Group	7.0	15.1	20.1	33.2	11.9	18.7	26.5	39.5
Subsidy eligible	--	--	--	--	17.2	18.2	31.3	43.1
Not subsidy eligible	--	--	--	--	8.4	19.0	23.5	37.3
Uninsured	28.1	16.0	36.7	48.2	20.4	16.8	31.8	41.6

Source: Rutgers Center for State Health Policy (see text for data sources)

Medicaid figures include dual eligible; adult eligibility adjusted for 5-year waiting period; excludes those in institutions or group quarters

-- Not applicable or data not available

*Insufficient sample size to support estimates

See Appendix B for definitions of health status variables

Table 4: Hospital Stays and Doctor Visits by Age and Health Status

	Utilization Measures (% of group)*	
Age Group and Health Status	Hospital Stay	3+ Doctor Visits
Children (under 19)	2.6	35.2
Fair/poor health	25.5	63.3
Excellent/very good/good health	1.9	34.4
Chronic condition (Asthma, Diabetes or Other)	9.2	46.5
No chronic conditions	1.4	33.0
Any of above health problems	9.4	46.7
No health problem	1.2	32.9
Non-Elderly Adults (19-64)	5.6	33.8
Fair/poor health	15.7	52.8
Excellent/very good/good health	3.8	30.5
Chronic condition (Asthma, Diabetes or Other)	12.9	55.5
No chronic conditions	3.1	26.3
Acute symptom	9.6	51.1
No acute symptoms	3.8	25.7
Any of above health problems	9.1	48.1
No health problem	2.6	21.6

Source: New Jersey Family Health Survey

*Past 12 months. Hospitalization for reason other than delivery of baby or as a newborn baby; visit to doctor or nurse practitioner.

Discussion

The Patient Protection and Affordable Care Act will require most New Jersey residents to obtain a qualifying health insurance plan by 2014. The ACA simplifies and expands eligibility for Medicaid up to 138% of the federal poverty level and provides sliding scale tax credits and cost sharing subsidies for the population ineligible for Medicaid and up to 400% FPL to purchase private coverage through health insurance exchanges. Some groups, including undocumented immigrants and persons receiving affordability exemptions, will not be required to obtain coverage and others are expected to pay federal penalties rather than purchase coverage. As New Jersey policymakers prepare for implementing their responsibilities under the ACA, it is important to know the size and characteristics of populations eligible for and likely to enroll in coverage.

This report draws on the most current available data on health insurance status and other population characteristics as well as information about health insurance purchasing behavior from published studies to generate estimates of the number and characteristics of persons by health insurance coverage status. Estimates for 2009 are derived using data from

the American Community Survey and the New Jersey Family Health Survey and project what coverage would have been in 2009 had the ACA been fully implemented in that year.

Our estimates show that under the ACA the number of uninsured New Jerseyans will decline from 14.5% of the non-elderly population to 8.6%, increasing the number of covered persons by about 444,000. The non-group health insurance market will gain the most covered lives, increasing from 2.8% of the non-elderly to 7.6%, an increase of about 362,000 persons. Of those projected to enroll in non-group coverage after reform, more than half will be eligible for federal tax credit subsidies. Medicaid will also expand substantially under reform, increasing from covering 13.6% to 16.7% of the non-elderly in the state, an expansion of 234,000 individuals. These changes would be accompanied by a projected decline of about 3.0% in persons with employer-sponsored coverage.

More than half of the projected increase in coverage under Medicaid will be non-parent adults (132,000 persons), although we project that the number of children in Medicaid will also increase by about 100,000. We project large increases in non-group coverage at all income levels, with the greatest increases among those below 400% FPL. Increased Medicaid coverage is concentrated below the 138% FPL threshold, but we also project a modest increase above that level, primarily through increased up-take by children already eligible for NJ FamilyCare.

Using an array of health status measures that are closely associated with health services utilization, we estimate that average health status of the population eligible for Medicaid after reform will be roughly the same or better than the currently enrolled population. If Medicaid take up is high after reform, actual enrollees will mirror this health status profile, but more adverse risk selection is probable if take up falls short.

Our estimates suggest adults over age 35 who are eligible for non-group coverage after reform will be somewhat sicker than their peers in the current non-group population. The risk profile of adults eligible for subsidies through health insurance exchanges is somewhat worse than the non-subsidy eligible, non-group target population. The finding is surprising in light of the long-standing problem of adverse selection against the Individual Health Coverage Program (IHCP) (Monheit et al., 2004). However, the pre-ACA non-group estimates presented here include individuals with Basic & Essential (B&E) plans, who are likely to be disproportionately healthy. In fact, enrollment in B&E plans has exceeded standard IHCP plan enrollment since the third quarter of 2008 (New Jersey Department of Banking and Insurance, 2010). Moreover, high premiums in the IHCP are likely to have posed significantly affordability barriers to many adults with poor health. These barriers will be overcome, at least to some extent, in 2014 when federal subsidies become available. The average cost of enrolled populations under the ACA will depend on the extent of compliance with the coverage enrollment mandate, thus public education, outreach and other measures to assure high compliance will be important as the ACA is implemented. These findings also underscore the need to establish a health insurance

regulatory structure that does not encourage higher risk persons to purchase coverage in the new health insurance exchange.

These estimates are based on the most current available data and the most rigorous published research on health insurance purchasing behavior, nevertheless a number of caveats apply. First, as noted, we project eligibility and enrollment under the ACA to the 2009 population. Demographic and/or policy changes between 2009 and 2014 may influence actual eligibility and enrollment. Overall, New Jersey's population is expected to grow very slowly during this period, but this growth will be concentrated in Asian and Hispanic populations suggesting that the share of immigrants in New Jersey will increase. The state population is also projected to age during this period, with increases in the number of persons transitioning to Medicare (Wu, 2011). These trends may modestly reduce the number of persons eligible for coverage under the ACA before 2014.

The projections in this report are also subject to other sources of error. First, the surveys on which the estimates draw are subject to sampling variation. We have suppressed estimates based on fewer than 40 sample observations because we view them as unreliable, but caution should be exercised in interpreting other estimates, especially those based on comparative small subgroups. Second, while we have sought to apply the most scientifically sound behavioral assumptions from the research literature, these estimates are based on national studies that are not New Jersey specific. Like the underlying data, these assumptions are subject to error. Nevertheless, we believe that the estimates provided in this report can be viewed as reasonable projections of the likely impact of the ACA in New Jersey.

Our estimates are similar to projections by others using different data sets and methods, although our estimates vary from these studies in some respects. As noted, we find that the total uninsured rate for the population under 65 is expected to decrease by 5.9 percentage points from 14.5% to 8.6% after implementation of the ACA. Using national data from the Current Population Survey (CPS), Buettgens, Holahan and Carroll (2011) find a similar order of magnitude of ACA impact, estimating that the NJ non-elderly uninsured rate would decrease by 8.6 percentage points to 8.9%; however, the CPS produces a higher rate of uninsurance in New Jersey pre-ACA than the ACS. We estimate a larger increase in Medicaid enrollment (22.8%) than Buettgens, Garrett and Holahan (2010) (18.8%), but the total number of expected enrollees is very similar. Our estimated post-ACA enrollment in non-group coverage is also nearly identical to that study. No other studies have provided comprehensive estimates of health status differences across enrolled and eligible populations.

While we were not able to describe in detail the characteristics of those who remain uninsured after health reform, other studies provide some suggestions about the composition of this group. Long, Phadera and Lynch (2010) reported that those adults who remained uninsured in Massachusetts in 2008 were more likely to be male, young, and single; racial/ethnic minorities and non-citizens; unable to speak English well or living in a household

with no adult who could speak English well. About 40% appeared to be eligible for some form of subsidized coverage, raising issues about targeted outreach for hard-to-reach groups. Buettgens and Hall (2011) made estimates of the uninsured for the Middle Atlantic region suggesting that the percentage eligible for Medicaid or an affordable coverage option may be higher in this area; however, the percentage of undocumented adults is also higher than in New England.

The projections in this report provide a snapshot at a point in time. ACA-related coverage may take time to phase in and will change over time. An important consideration is recent evidence of income fluctuations among lower-income adults. Using national survey data, Sommers and Rosenbaum (2011) estimated than more than 35% of all adults with family incomes below 200% FPL would experience a change in eligibility between Medicaid and an exchange coverage option, or the reverse, within six months. Nearly a quarter would have experienced at least two eligibility changes within a year, and 39% would have experienced this churning within two years. Eligibility changes were more likely for those with incomes between 100% and 150% FPL, those who were married, and those below age 30. Parents with children in the home were somewhat less likely to experience eligibility changes.

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Appendix A

Comparison of State Administrative Data to Survey Data, New Jersey Non-Elderly (Under 65) Population

	Data Source (thousands of persons)					
Source of Coverage	**State Administrative**		**ACS 2009**	**ACS 2009**	**CPS Pooled 2007-09**	**NJFHS 2009**
			Unadjusted	Adjusted	Unadjusted	Adjusted
Medicaid/NJ FamilyCare	1,089	*	899	1,027	728	659
0-18	648	*	496	596	406	364
19-64	441	*	403	431	322	295
Total Employer Sponsored	5,211	***	5,133	5,089	5,308	5,246
Small group-2-50	793	***	924	881	1,699 **	872
Large group-51+	4,418	***	4,209	4,208	3,609	4,374
Medicare (non-duals)/Tricare/VA	--		122	122	201	174
Nongroup	192	***	624	211	357	301
Uninsured	--		1,092	1,092	1,173	1,048

ACS is the American Community Survey; CPS is the Current Population Survey; and NJFHS is the New Jersey Family Health Survey

* Medicaid administrative records, July 2009

**CPS data are available only for groups of 2-99 employees

***NJ Department of Banking and Insurance data, 2009

-- Not available

Appendix B

Detailed Notes for Tables

Explanation of Estimates and Assumptions for Table 1

Medicaid/NJ FamilyCare

- Estimates of total adults and children enrolled in Medicaid pre-ACA include those who reported Medicaid enrollment in the ACS, plus individuals reclassified from non-group coverage who had family incomes which made them eligible for Medicaid/NJ FamilyCare. This number includes Medicare/Medicaid dual eligibles, but excludes otherwise eligible adults who have been in the U.S. less than five years and those in institutions or group quarters. While the total number of adults enrolled was similar to administrative records, it was not possible to identify all parents from the survey; therefore, the balance between parents and childless adults was adjusted based on administrative records as of July 2009.
- Estimates of income-eligible but not enrolled children and adults both before and after implementation of the ACA were made from the ACS, using the respective coverage rules.
- Estimates of take up by children eligible for NJ FamilyCare post-ACA were based on Kenney et al., 2010. We used the high end of the Kenney et al. confidence interval (79.9%-82.2%), since New Jersey is already employing the majority of practices recommended to increase enrollment, and enrollment efforts are likely to benefit from the additional activities associated with health reform. We assume that the Medicaid eligibility threshold for all adults (including parents) will be 138% FPL. Estimates of participation by adults newly eligible for Medicaid post-ACA used a take up rate of 73% based on Buettgens, Holahan, & Carroll, 2011 and Holahan & Headen, 2010. We also assume additional take up by adults already eligible due to increased outreach.

Employer-Sponsored Insurance

- Estimates of those eligible pre-ACA and those enrolled by size of group are based on the 2009 NJFHS.
- Estimates of those enrolled are based on coverage reported in the ACS. A small number of individuals reporting non-group coverage but also reporting that they were self-employed and incorporated were reclassified to ESI, based on published information about the over-reporting of direct purchase coverage in the ACS (Turner et al., 2009).
- Estimates of enrollment changes post-ACA are based on microsimulation results from Buettgens et al., 2010.

Private Non-Group Insurance

- The definition of non-group subsidy eligible includes family income of 139-400% FPL, legally resident, not exempt, and not non-compliant with mandate.
- Estimates of those enrolled pre-ACA are based on adjustments to the coverage reported in the ACS based on Turner et al., 2009. As mentioned above, individuals with family incomes which made them eligible for Medicaid/NJFamilyCare were reclassified, as well as a small number of individuals reclassified to ESI.
- Estimates of those enrolled post-ACA were based on estimates of those who could be expected to switch from ESI and those uninsured who were likely to enroll by Buettgens et al., 2010, who modeled eligibility for subsidies, affordability exemptions, and compliance with the federal coverage mandate. We also include parents over 138% FPL formerly covered by Medicaid/NJ FamilyCare.

Uninsured

- Estimates of the uninsured pre-ACA include those who reported no type of coverage.
- Estimates of those remaining uninsured post-ACA are the residual of those expected to enroll in all types of coverage.

Other Public

- Other public coverage includes those who reported being covered by Medicare (except for those also enrolled in Medicaid) and those enrolled in TRICARE and Veterans Administration programs.
- We did not estimate any change in enrollment for these programs post-ACA.

Explanation of Estimates and Assumptions for Table 2

- Estimates of income distribution are based on microsimulation results using an approximation of Modified Adjusted Gross Income (MAGI).
- Estimates of the income distribution for those enrolled in Medicaid/NJ FamilyCare were made using administrative records as of July 2009. Post-enrollment estimates were based on expected numbers of current and new enrollees among children and adults.
- Estimates of the post-ACA income distribution of those covered by private non-group coverage and those remaining uninsured were made using income distributions from Buettgens et al., 2011, which model income by health insurance eligibility units rather than family income as reported in the ACS.

Explanation of Estimates and Assumptions for Table 3

- Estimates of health status were developed from the 2009 NJFHS. Four measures are shown:
    - The percentage of individuals reported in fair or poor health (versus good, very good, or excellent).
    - The percentage reported with asthma, diabetes or any other serious or long-lasting health condition.
    - The percentage with acute symptoms reported within three months of the interview (available for adults only).
    - The percentage with any of the health problems noted above. For children, this summary measure includes only reports of fair/poor health and/or a chronic condition.
- Insurance coverage was available for all individuals; however, pairwise deletion is used if health status data are missing. Less than 3% of cases were missing any data.
- Data are suppressed where there was insufficient sample size to support estimates. Sample size limited the analysis to three age groups of non-elderly adults: 19-34, 35-49, and 50-64.
- Detailed information about NJFHS methods is available on the CSHP web site (http://www.cshp.rutgers.edu/Downloads/8610.pdf).

Explanation of Estimates and Assumptions for Table 4

- Estimates of hospital stays and doctor visits by age and health status were developed from the 2009 NJFHS. Sample sizes were insufficient for analysis using more specific age groups. In addition to the health status measures used in Table 3, we developed utilization measures consisting of (1) having a hospital stay within the past 12 months for reasons other than delivery of a baby or as a newborn baby, and (2) 3 or more visits to a doctor or nurse practitioner in the past 12 months.
- Individuals with all types of coverage (including the uninsured) are included in this analysis. Pairwise deletion was used if individuals were missing information on health status or utilization. Less than 5% of cases were missing any data.

RUTGERS

Center for State Health Policy

Center for State Health Policy
Rutgers, The State University of New Jersey
112 Paterson Street, 5th Floor
New Brunswick, NJ 08901

p. 848-932-3105 f. 732-932-0069
cshp_info@ifh.rutgers.edu
www.cshp.rutgers.edu